January 2011

Reg No

CHILDREN'S REGISTRATION FORM

Family Name:

First Name:

Date of Birth:

Ethnic Origin:

Mother and Father's Name:

Main Language:

Contact Telephone Number:

Address:

School:

Medical History

Any illnesses at birth or shortly after:

Any hospital admissions (please give date, hospital and reason):

Any operations (please specify):

Any other illnesses, e.g. Eczema, Asthma, Diabetes, or accidents:

Any regular medications taken:

Any allergies:

Vaccinations

Please supply the dates your child had the following vaccinations:

Vaccination	1st dose	2nd dose	3rd dose	Booster	2nd Booster
Diphtheria					
Tetanus					
Pertussis					
Polio'					
HIB					
Pneumococcus					
Meningitis C					
Mumps					
Measles					
Rubella					
Hepatitis B					
Hepatitis A					
Typhoid					
BCG					
Other:					

Any further information you would like to give– Please detail overleaf
E.g. special needs at school